

Improvement Targets and Initiatives



Manitowadge General Hospital, 1 Health Care Crescent, Manitowadge Ontario

AIM		MEASURE				CHANGE					
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments	
Safety	Reduce clostridium difficile associated diseases (CDI)	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	0	stay below provincial average (currently .29)	3	1) follow through with hand hygiene improvement initiatives	Tracking through infection control and public reporting data	stay below the provincial average	Based on best practice guidelines and provincial averages as a comparison		
						2)review existing policies and procedures for best practice	Infection control committee to review and update policies and procedures. Review will be dated.	P&P will be reviewed and updated with any new best practice guidelines	Based on best practice guidelines		
	Reduce incidence of Ventilator Associated Pnemonia (VAP)	VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	n/a we do not have an ICU				1)				
							2)				
							... N)				
	Improve provider hand hygiene compliance	Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - 2009/10, consistent with publicly reportable patient safety data	71.25	Improve our hand hygiene compliance to 75%	2		1)Promotional educational campaign	Annual audit of Hand hygiene compliance by Infection control	Improve our hand hygiene compliance to 75%	Based on best practice guidelines and provincial averages as a comparison	
							2)completion of an on-line educational program for all staff	Staff will hand in certificate once completed. Results will be analyzed.	100% of staff will complete the program	Improve knowledge and provide education.	
							... N)				
	Reduce rate of central line blood stream infections	Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	n/a we do not have an ICU				1)				
							2)				
							... N)				
Avoid new pressure ulcers	Pressure Ulcers: Percent of Long Term Care (LTC) residents with new pressure ulcer in the last three months (stage 2 or higher) - FY 2009/10, CCRS	0	Stay below provincial average (currently .28)	3		1)ensure best practice guidelines (BPG) are current and utilized	Staff to review P&P. New P&P, BPG to be posted for staff.	Ulcer rate to stay below provincial average (currently .28)	Best practice guidelines and provincial averages as a comparison		
						2)Monitor ulcer data through RAI data	Monitoring and tracking of ulcer indicator data utilizing RAI data	s/a	s/a		
						... N)					
Avoid falls	Falls: Percent of Long Term Care residents who do not have a recent prior history of falling, but fell in the last 90 days - FY 2009/10, CCRS	0	stay below the provincial average	3		1)1)ensure best practice guidelines (BPG) are current and utilized	Staff to review P&P. New P&P, BPG to be posted for staff.	Fall rate to stay below the provincial average	Best practice guidelines and provincial averages as a comparison		
						2))Monitor ulcer data through RAI data	Monitoring and tracking of ulcer indicator data utilizing RAI data	s/a	s/a		

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	Safety huddles/briefings will be incorporated into every department	Safety huddles/briefings - Number of completed weekly safety briefings with documentation by departments based on total # of weeks	no current data available	80 % compliance rate	1	1) Distribute policy and tracking sheet to all department Charges and explain the process	Tracking sheets to be handed in to QA and analyzed	80 % compliance rate	Accreditation Canada	
						Integrate improvements into future QIP's as identified and appropriate	QA committee will make recommendations based on analyzed data	New initiatives will be incorporated into the 2012/13 plan as recommended by QA	s/a	
	Improve admission process	Open order sets utilized upon admission in relation to total admissions	nil project in beginning stages	have the open order set initiative ready for use by all physicians	1	1) Collaborate with Northshore Hospitals and the vendor as we build our hospital specific order sets. Collaborate with local physicians with regards to the formation of the order sets.	CNO will be the lead on the project and update at regular MAC meetings	Order set initiative for the admission process will be ready for use by April 1, 2012	Incorporates best practices into the admission process and links them via the software and website. Will improve patient safety by eliminating potential errors	
Effectiveness	Reduce unnecessary deaths in hospitals	HSMR: number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	n/a			2)				
						... N)				
	Reduce unnecessary hospital readmission	Readmission within 30 days for selected CMGs to any facility: The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q1 2010/11, DAD, CIHI	n/a	do not have expected non-elective readmissions		1)				
						2)				
						... N)				
	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2010/11, DAD, CIHI	0 as per LHIN Q2 data	Stay within 25.9% LHIN specified target	2	1) CNO to work with CCAC placement in efforts to expedite ALC transfers upon bed availability	CNO will contact CCAC with every bed vacancy on the first working day	Stay within 25.9% LHIN specified target	Ensure best available beds are utilized within the proper care setting.	
						2) If LTC admission to vacant room is delayed beyond 3 working days, SMT and/or CNO will be notified for enhanced management strategy	Nurse manager will report all delayed admissions	Fill all vacant rooms within 3 working days	s/a	
						... N)				
	Improve organizational financial health	Total Margin (consolidated): Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Q3 2010/11, OHRS	10.05% per WERS Q3 data	Stay within LHIN target of 0.0% for 2010/2011	3	Maintain current fiscal balance.				
	Space for additional indicators									
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	48 minutes (.008 hrs)	Stay below the provincial target of 8 hours	3	1) Monitor				
						2) Investigate all cases above the 8hr provincial target and develop action plan as appropriate	Health Records to provide LOS data for analysis	Stay below the provincial target of 8 hours	provincial targets	
						... N)				
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI - Triage 1, 2 & 3 levels used for data. Used January 1 - December 31, 2010 data.		5.16	Stay below the provincial target of 8 hours	3	1) Monitor	Health Records to provide LOS data for analysis		
						2) Investigate all cases above the 8hr provincial target and develop action plan as appropriate				
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Patient-centred	improve patient satisfaction	<i>Please choose the question that is relevant to your hospital:</i>	100 % response as excellence for in patients 96% satisfaction rate for emergency patients In-house survey (if available): provide the percent response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP) Our related question is " How would you describe your overall care by our hospital team? - poor, fair, good, excellent. This data is current and will be our baseline data.	80% achievement within the good and/or excellent response range	1	1)Review and revise our questionnaires to add on the question "Willingness of patients to recommend the hospital to friends and family.	QA committee will review and revise our existing questionnaire	Survey changes will be complete by June 30, 2011	To have data available as per the QIP template.	
		2)QA to monitor and audit the responses for input and planning to improve services and client satisfaction				QA will review survey data and make recommendations to the Board Quality committee of ECFAA	annual report to be given	Hospital target		
		3) Integrate improvement opportunities into the QIP				Board Committee will integrate improvements into the QIP as appropriate	annual review and revision of QIP			
	improve Staff satisfaction	Utilizing the Worklife Pulse Tool" (Accreditation Canada) we will provide from the staff survey a percentage to the following question. Overall, I am satisfied with this organization. The following scale is used. Strongly disagree - Disagree - Neutral - Agree Strongly - Agree	79.1 % (2009 data)	80%	1	Complete staff satisfaction surveys as per Bill 46 (every 2 years) utilizing the "Worklife Pulse Tool" (Accreditation Canada) survey.	all surveys will be tracked and analyzed for satisfaction rate	80 % satisfaction	Hospital target	
					When organizational status falls below 80% send a follow up survey for staff input on how the organization could potentially improve on the identified areas of concern.	s/a	s/a			
					Implement appropriate recommended changes into QIP	Board Committee will integrate improvements into the QIP as appropriate	s/a			